U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 September 2004

CASE NO.: 2002-BLA-5216

In the Matter of

JESSE D. TAYLOR,
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Jesse D. Taylor, *pro se*

Douglas A. Smoot, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on February 15, 2001, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his first prior claim for benefits on April 29, 1970. (Director's Exhibit ("DX") 33). The claim was denied because the evidence failed to establish Mr. Taylor was totally disabled due to pneumoconiosis. (DX 33-18). The Claimant did not appeal the denial.

The claimant filed a second claim for benefits on December 23, 1997. (DX 34). The Department of Labor denied the claim on March 17, 1998. The Claimant appealed the denial and an informal conference was held on June 5, 1998. On October 6, 1998, the Department of Labor issued a Proposed Decision and Order/Memorandum of Conference. (DX 34-38). The Department of Labor determined that Mr. Taylor had proven coal workers' pneumoconiosis. The claim was denied, however, because the evidence failed to establish that Mr. Taylor was totally disabled due to pneumoconiosis. (DX 34-38). The Claimant did not appeal the Department of Labor findings.

The claimant filed his current claim for benefits on February 15, 2001. (DX 1B). On February 20, 2002, the claim was denied by the district director because the evidence failed to establish the elements of entitlement that Mr. Taylor was totally disabled due to pneumoconiosis. (DX 19). On March 19, 2002, the claimant requested a hearing before an administrative law judge. (DX 32). On June 13, 2002, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on September 9, 2002. Thereafter, the case was continued numerous times by orders of the undersigned and other administrative law judges assigned to the case. I was reassigned the case on February 3, 2004.

On June 29, 2004, I held a hearing in Charleston, West Virginia, at which the claimant represented himself and employer was represented by counsel.[1] A prior hearing date was continued for Claimant to retain counsel. After difficulty trying to find an attorney, Claimant decided to represent himself at the scheduled hearing. No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-3, Director's exhibits ("DX") 1-36, and Employer's exhibits ("EX") 3, 5-10, and 14-16 were admitted into the record.[2] Employer submitted a closing brief post-hearing.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the act and the Regulations?

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[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[2] Employer's Exhibits 1, 2, 4, 11-13 and the October 19, 2002 X-ray included in exhibit 10 were not admitted due to exceeding the evidentiary limitations of 20 C.F.R. § 725.414.

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a material change in the claimant's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 34 years. The claimant's employment history form (Form CM-911a) notes various coal mine jobs from 1960 until 1997. At the hearing, the Claimant testified that he began working in the mines in 1960, spent approximately two years in the army, and retired from coal mine work in 1997. Claimant's Social Security records prove at least 34 years of coal mine employment. (DX 6 & 7; TR 13-16).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on February 15, 2001. (DX 1-B). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[3]

Consolidation Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations. (DX 4).

D. Dependents[4]

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife Esta. (DX 11; TR 22).

E. Personal and Employment History

The claimant was born on May 20, 1941. (DX 1B). He married Esta Taylor, on December 9, 1964. (DX 11). The Claimant's last position in the coal mines was that of a

[3] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.
[4] See 20 C.F.R. §§ 725.204-725.211.

mechanic. His previous coal mine jobs include shop foreman and cutting machines operator. (TR 16-17).

II. Medical Evidence

The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[5]

There were twelve readings of six X-rays, taken on September 26, 1995, January 26, 1998, September 23, 1999, March 14, 2001, November 14, 2001, and November 12, 2002.[6] (DX 15 & 16; EX 3, 5, 6, 9 &10; CX 1). Three are positive, by three physicians, Drs. Willis and Zaldivar, and a doctor from the Radiological Physicians Association, all of whom are either B-readers, Board-certified in radiology, or both.[7] Eight are negative, by three physicians, Drs. Navani, Renn, and Wiot, all of whom are either B-readers, Board-certified in radiology, or both.[8] A reading of the March 14, 2001 X-ray by Dr. Navani was a quality only reading.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 15	11/12/2002 4/18/2003	Dr. Wiot	B, BCR	2		No evidence of coal workers' pneumoconiosis. There is questionable minimal interstitial change present at both bases. The upper lung fields are clear.

[5] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[6] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[7] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

[8] *Cranor v. Peabody Coal Co.,* 21 B.L.R.1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's X-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on X-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 6	11/12/2002 11/12/2002	Dr. Renn	B, BCI(P)	2		No abnormalities consistent with pneumoconiosis.
EX 3	11/14/2001 10/18/2002	Dr. Wiot	B, BCR	1		No evidence of coal workers' pneumoconiosis. There is bibasilar minimal interstitial fibrosis, most prominent on the left.
DX 30	11/14/2001 11/19/2001	Dr. Willis	B, BCR	1	1/1	p, q All zones. Parenchymal opacities scattered throughout both lungs, consistent with occupational pneumoconiosis.
EX 5	3/14/2001 11/27/2002	Dr. Wiot	B, BCR	1		No evidence of coal workers' pneumoconiosis. There is bibasilar minimal interstitial fibrosis, most prominent on the left.
DX 16	3/14/2001 5/19/2001	Dr. Navani	B, BCR	2		Quality only reading. Overlying Rt. Scapula.
DX 15	3/14/2001 4/28/2001	Dr. Zaldivar	B, BCP	1	1/1	q, q All zones.
EX 10	9/23/1999 2/6/2003	Dr. Wiot	B, BCR	2		No Evidence of pneumoconiosis. The chest is within normal limits.
CX 1	9/23/1999 9/29/1999	TBH (initials) Radiological Physicians Association	B	2	1/1	q/q All zones.
EX 5	1/26/1998 11/27/2002	Dr. Wiot	B, BCR	1		No evidence of coal workers' pneumoconiosis. There is bibasilar minimal interstitial fibrosis, most prominent on the

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						left.
EX 9	9/26/1995 10/4/1995	TBH (initials) Radiological Consultants Assoc.	B	1	0/1	
EX 10	9/26/1995 2/6/2003	Dr. Wiot	B, BCR	1		No evidence of pneumoconiosis. The chest is within normal limits.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[9]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Trac-ings	Comp-rehension Cooper-ation	Qualify * Conform **	Dr.'s Impression
Dr. Renn	61	1.86	71	2.58	Yes	Good	Yes	Spirometry is

[9] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Trac-ings**	**Comp-rehension** **Cooper-ation**	**Qualify *** **Conform ****	**Dr.'s** **Impression**
11/12/2002 EX 6	71'					Fairly good	Yes	consistent with a moderately severe restrictive defect.
Dr. Renn 11/12/2002 EX 6 Post-Bron	61 71'	2.25	67	2.98	Yes	Good Fairly good	No Yes	Significant post-bronchodilator improvement thereby revealing a concomitant obstructive airway disease. MVV is invalid.
Dr. Crisalli 11/14/2001 DX 30	60 72'	2.46	63	3.32	Yes	Good Good	No Yes	
Dr. Crisalli 11/14/2001 DX 30 Post-Bron	60 72'	2.79		3.71	Yes	Good Good	No Yes	
Dr. Zaldivar 3/14/2001 DX 12	59 71'	2.26	93	3.42	Yes	Good Good	No Yes	
Dr. Zaldivar 3/14/2001 DX 12	59 71'	2.27	103	3.13	Yes	Good Good	No Yes	

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Trac-ings**	**Comp-rehension** **Cooper-ation**	**Qualify *** **Conform ****	**Dr.'s Impression**
Post-Bron								
Dr. Conley 9/23/1999 CX 2	58 72'	2.30		3.47	Yes		No Yes[10]	Moderate Obstruction.
Dr. Conley 9/23/1999 CX 2	58 72'	2.31		3.52	Yes		No Yes	Moderate obstruction.
Dr. Conley 9/23/1999 CX 2	58 72'	2.00		3.38	Yes		No Yes	Moderate Obstruction.
Dr. Conley 9/26/1995 EX 9	54 71'	3.28		4.60	Yes		No Yes	Normal
Dr. Conley 9/26/1995 EX 9	54 71'	3.24		4.51	Yes		No Yes	Normal
Dr. Conley 9/26/1995 EX 9	54 71'	3.19		4.65	Yes		No Yes	Mild Obstruction

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

[10] As noted below, Dr. Renn reviewed the September 23, 1999 pulmonary function study by Dr. Conley. He concluded that the study is invalid by American Thoracic Society criteria.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

Dr. Renn reviewed the spirometry study of September 23, 1999. Dr. Renn cited three reasons the September 23, 1999 spirometry study is invalid by American Thoracic Society criteria:

1. One of the three FVC tracings reveals failure to maintain maximal effort throughout the entire FVC maneuver. The effect resultant from this is underestimation of the FEV1.
2. The midportion of the FVC tracing was not copied thereby preventing determination of the duration of the FVC maneuver. Certain parameters of quality control cannot be applied.
3. The practical limit of eight FVC maneuvers was not provided to result in three acceptable studies.

(EX 14).

For a miner of the claimant's height of 71.4 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 2.17 for a male 61 years of age.[11] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.76 or an MVV equal to or less than 87; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	**Age**	**FEV_1**	**FVC**	**MVV**
71	61	2.14	2.72	85
72	60	2.20	2.82	89
71	59	2.17	2.76	87

[11] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 71.4" here, his average reported height.

72	58	2.25	2.85	90
71	54	2.25	2.84	90

C. Arterial Blood Gas Studies[12]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date **Ex. #**	**Physician**	**PCO2**	**PO2**	**Qualify**	**Physician Impression**
11/12/2002 EX 6	Dr. Renn	44	80	No	Arterial blood gases are normal for age.
11/14/2001 DX 30	Dr. Crisalli	41	95	No	
3/14/2001 DX 14	Dr. Zaldivar	33 32*	104 92*	No No	Exercise stopped due to chest pain. Blood gases showed normal resting and exercise values. Advised to see his physician because of chest pains occurring simultaneous with multiple premature ventricular contractions. Possible coronary artery disease.

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respirator or cardiac illness."

[12] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

D. Physicians' Reports and Depositions

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

On July 3, 2003, Dr. Wiot, a B-reader and Board-certified radiologist, was deposed by Employer's counsel. (EX 16). Dr. Wiot explained what needs to be seen on a chest X-ray to diagnose coal workers' pneumoconiosis:

> Well, coal workers' pneumoconiosis is manifested radiographically by the presence of small, rounded and sometimes irregular opacities, which tend to begin in the upper lung fields. They more often, interestingly enough, they early occur in the right upper lung field rather than the left. These rounded or irregular opacities are more often what we call a q size, which is a part of he classification system, but, you know, you can have p's and r's, but more often q size opacities of coal workers' pneumoconiosis and sometimes t's.

(EX 16, p.18). Dr. Wiot testified that when interpreting chest X-ray films, his practice is to give the benefit of the doubt to the patient in finding coal workers' pneumoconiosis. (EX 16, p.21).

Dr. Wiot interpreted three of Mr. Taylor's chest X-rays. He interpreted the March 14, 2001 X-ray as negative for pneumoconiosis. Dr. Wiot did find minimal basilar interstitial fibrosis and a few calcified lymph nodes in the left hilum. He explained that basilar changes are not related to coal dust exposure. Dr. Wiot interpreted the November 14, 2001 X-ray as negative for pneumoconiosis. He again found basilar interstitial fibrosis. Dr. Wiot made the same finding for the November 12, 2002 X-ray. Dr. Wiot did not find any evidence of Bullae in the three X-ray films. (EX 16, pp.21-30). Dr. Wiot testified that Mr. Taylor has "absolutely no evidence of coal workers'" pneumoconiosis. (EX 16, p.31).

Dr. Renn is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary disease. His examination report, based upon his examination of the claimant, on November 12, 2002, noted that he began working in the coal mines in 1960 and quit in 1997 due to his inability to keep up with the work as a result of exertional dyspnea. Claimant has no smoking history. (EX 6). Dr. Renn described the claimant's symptoms as exertional dyspnea since 1981. Dr. Renn also noted that the Claimant experienced daily cough and sputum production a few days a week. He noted that the Claimant does not have wheezing. Claimant uses inhalers numerous times every day. (EX 6).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Renn diagnosed extrinsic asthma. He stated that pneumoconiosis does not exist and the asthma was not

caused by coal dust exposure. Dr. Renn interpreted the chest radiograph as having no abnormalities consistent with pneumoconiosis. Dr. Renn also noted the "spirometry is consistent with a moderately severe restrictive ventilatory defect; however, there is significant post-bronchodilator improvement thereby revealing a concomitant obstructive airway disease." Dr. Renn concluded that the ventilatory defect is due to Mr. Taylor's asthma. Dr. Renn stated that the Claimant is not totally and permanently impaired. (EX 6).

Dr. Renn determined that the post-bronchodilator MVV is invalid because it does not correlate with the contemporaneously performed FEV1. (EX 6). Dr. Renn concluded that the lung volumes reveal a mild restrictive ventilatory defect and the air trapping of an obstructive ventilatory defect. He determined that the diffusing capacity study is invalid. Dr. Renn noted that the results of the resting arterial blood gas are normal. (EX 6).

Dr. Crisalli is a B-reader and Board-certified in internal medicine and pulmonary disease. He submitted an examination report, dated November 29, 2001, based on his examination of the claimant on November 14, 2001. (DX 30). Dr. Crisalli described the claimant's symptoms as 23 to 25 years of dyspnea, 22 years of daily cough and sputum production, chest pain, orthopnea and paroxysmal nocturnal dyspnea. (DX 30).

Dr. Crisalli did not perform an exercise blood gas study because of Claimant's history of cardiac difficulty during exercise studies. Dr. Crisalli stated that the pulmonary function study shows a mild restrictive defect and a mild diffusion defect. Dr. Crisalli stated that "[t]he restrictive defect seen on pulmonary functions is mild and may be related to the simple coal workers' pneumoconiosis, although I believe this would be unlikely considering the degree of X-ray changes seen." (DX 30).

Based on his examination, Dr. Crisalli diagnosed Mr. Taylor with simple coal workers' pneumoconiosis, chronic bronchitis and asthma, chest pain (noncardiac by history) and arthritis. Dr. Crisalli diagnosed coal workers' pneumoconiosis based on the Claimant's 35 years of coal mine work and an abnormal chest X-ray. Dr. Crisalli found a mild restrictive defect. Dr. Crisalli based his diagnosis of chronic bronchitis and asthma on the Claimant's history of cough productive of sputum daily for 22 years and evidence of reversibility in the pulmonary function studies. (DX 30).

Dr. Crisalli concluded that Mr. Taylor's pulmonary impairment is "extremely mild." Furthermore, "Mr. Taylor retains the pulmonary functional capacity to perform his previous job in the coal mines or a job requiring similar effort outside of the mines from the standpoint of his pulmonary functional standpoint." (DX 30).

On December 18, 2002, Dr. Crisalli was deposed by Employer's counsel. (EX 7). Dr. Crisalli explained the difference between asthma and coal workers' pneumoconiosis:

> Asthma is very different than coal workers' pneumoconiosis. Pathologically, asthma is a disease of inflammation of the airways where one develops swelling, increased mucous production, and the muscles around the airways become very sensitive and clamp down thereby narrowing the airway. Asthma is basically an airway disease.

> Pneumoconiosis is a disease where dust deposits create a reaction in the lungs. So if a person inhales dust, provided he is susceptible to the dust, he may develop small changes that are called coal dust macules, which are basically little areas of fibrosis in reaction around the coal dust.
>
> Coal workers' pneumoconiosis does not have the swelling and the inflammation that you see in asthma.

(EX 7, pp.5-6). Dr. Crisalli examined Mr. Taylor, on November 14, 2001. He noted that Mr. Taylor worked in the coal mines for thirty-five years, which is sufficient exposure to coal dust to cause coal workers' pneumoconiosis in a susceptible individual. Dr. Crisalli also noted that Claimant never smoked cigarettes. Dr. Crisalli classified Mr. Taylor's coal mine work, in terms of exertional requirement, as medium work. (EX 7, p.7). Dr. Crisalli described the Claimant as suffering from shortness of breath, cough and sputum production, for over twenty years. Dr. Crisalli noted that shortness of breath and cough production are non-specific symptoms and occur in various lung diseases. (EX 7, p.9).

Dr. Crisalli stated that Mr. Taylor uses a Serevent inhaler, a Flovent inhaler and an Albuterol inhaler. Dr. Crisalli explained that the only time he sees these medications helping patients with coal workers' pneumoconiosis is where there is some other cause of the inflammation in addition to the coal workers' pneumoconiosis. (EX 7, pp.10-12).

During his examination, Dr. Crisalli found no evidence of lung obstruction. He stated that the pulmonary function study performed during the examination showed a restrictive defect and did not show an obstructive defect for the pre-bronchodilator study. An obstructive defect was found in the post-bronchodilator study. Dr. Crisalli concluded that the restrictive and obstructive defects are mild. (EX 7, pp.14-16). Dr. Crisalli concluded that none of Mr. Taylor's pulmonary defects are severe enough to be totally disabling. (EX 7, p.17).

Dr. Crisalli testified regarding the pulmonary function study performed by Dr. Zaldivar, dated March 14, 2001. He stated that Dr. Zaldivar's test does not show any evidence of restriction. Dr. Crisalli stated that Dr. Zaldivar's lung volume study may not be accurate. Additionally, Dr. Crisalli noted the similarity between his results and Dr. Zaldivar's results. (EX 7, pp.19-22).

Dr. Crisalli also discussed the pulmonary function study performed by Dr. Renn, dated November 12, 2002. Dr. Crisalli stated that the pre-bronchodilator values of Dr. Renn's test are lower than those obtained by Dr. Zaldivar and himself. He also stated that Dr. Renn's post-bronchodilator values show significant improvement. (EX 7, p.22). He explained that Dr. Renn's study, taken in isolation, shows a moderate obstruction. He further stated, however, that taking all the studies into account shows a mild obstruction. Dr. Crisalli testified that "[t]aking all these studies together, I think this gives support to the diagnosis of asthma." (EX 7, p.24).

Dr. Crisalli reviewed the arterial blood gas studies performed on Mr. Taylor. He stated that the arterial blood gas performed by Dr. Zaldivar shows results within normal limits. Dr. Crisalli explained that Dr. Renn's arterial blood gas study presents lower results, but it is still within normal range. (EX 7, p.26).

Dr. Crisalli stated that the X-ray performed at his examination of Mr. Taylor shows a profusion of 1/1, involving all lung zones. He explains that the result is consistent with coal workers' pneumoconiosis. Dr. Crisalli diagnosed Mr. Taylor with simple coal workers' pneumoconiosis, chronic bronchitis and asthma. (EX 7, p.29).

Dr. Zaldivar, a B-reader and Board-certified pulmonologist, submitted an examination report, dated. March 14, 2001. Dr. Zaldivar examined the Claimant at the request of the Department of Labor. (DX 13). Dr. Zaldivar noted that the Claimant never smoked and worked in the coal mines from 1966 through 1997. He described the Claimant's symptoms as daily sputum, cough and chest pain. (DX 13).

Dr. Zaldivar interpreted Claimant's chest X-ray with a 1/1 profusion. The pulmonary function study showed a mild obstruction with air trapping. The results of an arterial blood gas were normal. Dr. Zaldivar found a mild pulmonary impairment due to pneumoconiosis. He concluded that such impairment would not interfere with his usual coal mine work. (DX 13).

On January 6, 2003, Dr. Zaldivar was deposed by Employer's counsel. (EX 8). Dr. Zaldivar testified that the examination he takes for the Department of Labor is less complete than a normal examination in his office. He explained that the Department of Labor "form" does not give as much information as the history and physical examination which he takes personally. He further stated that an examination performed by the Department of Labor provides a "fair picture" of an individual's health, but it is not as complete as when it is performed under the usual conditions. (EX 8, pp.5-6).

Dr. Zaldivar interpreted Mr. Taylor's chest X-ray as showing simple pneumoconiosis, with a 1/1 profusion. (EX 8, p.8). Dr. Zaldivar stated that other than claimant's history of hay fever, he does not have any history consistent with asthma. Dr. Zaldivar explained that Mr. Taylor's symptoms of cough and sputum production are non-specific to any particular condition. (EX 8, p.12). He further explained that pneumoconiosis causes an obstruction when there is pulmonary damage, but it does not cause increased production of sputum. (EX 8, p.13).

Dr. Zaldivar stated that Mr. Taylor's breathing tests illustrate a mild airway obstruction. He explained that there was no improvement after administering bronchodilators. (EX 8, p.14). Dr. Zaldivar determined that the blood gases were normal at rest and with exercise. (EX 8, p.18). Dr. Zaldivar opined that Mr. Taylor has a mild airway obstruction, attributed to his coal mine dust exposure. He further stated that the obstruction has no clinical significance. Dr. Zaldivar also found a mild diffusion impairment, but he said it is too mild to interfere with gas exchange. (EX 8, p.20).

Dr. Zaldivar explained how much reversibility is necessary to find an asthmatic component: "the absolute FEV1 should improve by two hundred cc's minimum, and the improvement should be thirteen percent or better. Both conditions have to be met." (EX 8, p.24). He concluded that the Claimant did not have asthma.

Dr. Zaldivar concluded that Mr. Taylor does not have a totally disabling pulmonary impairment. He found the impairment mild. Dr. Zaldivar testified that Mr. Taylor has the pulmonary capacity to perform heavy labor. (EX 8, pp.24-25).

The Claimant's treating physician, Dr. Farooq, referred him to South Charleston Cardiodiagnostics for evaluation of Claimant's chest pain. On March 23, 2001, Dr. Wazir performed a stress test on Mr. Taylor. Dr. Wazir found a normal dual isotope perfusion scan and normal left ventricular function and wall motion. The test conclusions are listed as follows:

1. Non-diagnostice ECG stress test at achieved heart rate of 122/BPM.

2. Chest pain started at 2 minutes and 45 seconds at heart rate of 189/BPM.

3. No arrhythmia.

(DX 28).

III. Claimant's Testimony

Claimant testified at the June 29, 2004 hearing regarding his work history and health problems. (TR 13). Claimant stated that he started working in the coal mines in 1960. Mr. Taylor was drafted into the Army in 1964 and released from service in 1966. (TR 14). Upon his release from the Army in 1966, Mr. Taylor worked for the same coal company in the same job he had when he left to enter service. Mr. Taylor stated that he continued working in the coal mines until 1997. Mr. Taylor explained that he ceased working for Consolidation Coal Company in 1997 because he could not "carry the load" required to perform his job duties because of his difficulty breathing. (TR 16).

Mr. Taylor characterized his coal mine work as heavy labor. He explained that he could not currently perform his previous coal mine work because of his breathing problems. (TR 20-21). Mr. Taylor testified that he has never smoked. (TR 21).

In October 1999, Mr. Taylor had a state black lung examination. He received 25% state disability for black lung. (TR 17; DX 9). He explained that his breathing problems began in the 1980's. In 1981, he received a 5% state disability for lung problems. (TR 18). Claimant also submitted a 2000 West Virginia tax form listing him as a permanently and totally disabled taxpayer. The form is signed by Dr. Ahmed Farooq on April 30, 2001. (CX 3).

Mr. Taylor stated that he used to be a hunter. He explained that he can no longer hunt because he can no longer drag dear or climb hills. Mr. Taylor stated that he began having difficulties hunting in the 1990's. Mr. Taylor can go fishing as long as he is on level ground. (TR 18).

Mr. Taylor stated that he uses a nebulizer and the doctor directed him to use it every four hours. He also uses inhalers. Mr. Taylor explained that his chest hurts about 80% of the time. (TR 18-19). Mr. Taylor testified that he has cough with sputum production in the mornings. He also has to sleep on an incline. (TR 20).

Mr. Taylor stated that his treating physician, Dr. Farooq, concluded he is totally disabled. (TR 22).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281.

Since this is the claimant's third claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.[13] Although the new regulations

[13] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Sections 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

dispense with the "material change in conditions" language of the older regulations, the criteria remain similar to the "one-element" standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), which was adopted by the United States Court of Appeals for the Fourth Circuit, in *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). In *Dempsey v. Sewel Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004), the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless the administrative law judge finds that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. § 725.309(d); *White v. New White Coal Co., Inc.*, 23 B.L.R. 1-1, 1-3 (2004). According to the Board, the "applicable conditions of entitlement" are "those conditions upon which the prior denial was based." 20 C.F.R. § 725.309(d)(2).

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of October 6, 1998, i.e., disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale,* the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n. 11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.*), the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that a miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions…"

The claimant's second application for benefits was denied because the evidence failed to show that the claimant was totally disabled by pneumoconiosis. (DX 34-38). Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[14] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[15]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[16] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14

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[14] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co*., 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[15] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

[16] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[17] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence.[18] 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8

[17] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

[18] "There are twelve levels of profusion classifications for the radiographic interpretation of simple pneumoconiosis…*See* N. LeRoy Lapp, '*A Lawyer's Medical Guide to Black Lung Litigation*,' 83 W.Va. Law Rev. 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th cir. 1996)(*en banc*) at 1359, n.1.

B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

Two doctors interpreted the most recent X-ray, dated November 12, 2002. Both doctors determined there was no evidence of pneumoconiosis. Thus, I conclude the November 12, 2002 X-ray is negative for pneumoconiosis.

The November 14, 2001 X-ray was interpreted by two dually qualified doctors. Dr. Wiot concluded there was no evidence of coal workers' pneumoconiosis. Dr. Willis, however, interpreted the X-ray to have a 1/1 profusion. As such, I find the November 14, 2001 X-ray neither precludes nor establishes the presence of pneumoconiosis.

I also find the March 14, 2001 X-ray neither precludes nor establishes the presence of pneumoconiosis. It was read as negative by a dually qualified physician. Dr. Zaldivar, a B-reader and Board-certified pulmonologist, interpreted the X-ray as positive for pneumoconiosis, with a profusion of 1/1.

I find the September 23, 1999 X-ray is negative for pneumoconiosis. A dually qualified physician interpreted the X-ray as having no evidence of pneumoconiosis. A B-reader, who is part of the Radiological Physicians Association and noted by initials only, read the X-ray as positive for pneumoconiosis, with a profusion of 1/1. I also found the January 26, 1998 and September 26, 1995 X-rays negative for pneumoconiosis. All readings of these X-rays were interpreted as negative.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not

be considered sufficiently reasoned if the underlying objective medical data contradicts it.[19] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). The record contains medical reports by Drs. Crisalli, Renn and Zaldivar. It also contains deposition testimony by Dr. Wiot. As noted above, all of these doctors have expertise in the field. All four doctors are B-readers and have various Board-certifications.

Dr. Crisalli examined the Claimant on November 14, 2001. Dr. Crisalli diagnosed coal workers' pneumoconiosis. He also diagnosed asthma and chronic bronchitis. Dr. Crisalli reiterated his conclusions at a deposition on December 18, 2002. Dr. Crisalli based his diagnosis of coal workers' pneumoconiosis on Claimant's work history and abnormal chest X-ray. At his deposition, Dr. Crisalli gave a detailed explanation of the difference between coal workers' pneumoconiosis and asthma. Dr. Crisalli provided a thorough examination. He discussed claimant's work history, his history as a non-smoker and his physical symptoms in making his conclusion.

Dr. Renn examined the Claimant on November 12, 2002. Dr. Renn diagnosed the claimant with Asthma. He concluded that the claimant does not have pneumoconiosis and that his asthma was not caused by coal dust exposure. Dr. Renn also provided an accurate discussion of Claimant's work history, smoking history and medical history.

Dr. Wiot was deposed regarding his interpretation of three X-ray films of Mr. Taylor. Dr. Wiot provided detailed testimony regarding diagnosing coal workers' pneumoconiosis. Dr. Wiot has extensive experience and expertise in interpreting chest X-rays for coal workers' pneumoconiosis. He read the three X-rays of Mr. Taylor as showing no evidence of pneumoconiosis.

Dr. Zaldivar performed the claimant's Department of Labor examination. Dr. Zaldivar accurately noted the Claimant's work, non-smoking and medical history. Dr. Zaldivar diagnosed the claimant with simple coal workers' pneumoconiosis. Dr. Zaldivar did not diagnosis Claimant with asthma. He reiterated this diagnosis at a January 6, 2003 deposition.

Drs. Crisalli and Renn diagnosed Claimant with asthma, although the Claimant did not testify he had asthma or communicate to the examining doctors that he "wheezed."[20] Dr. Renn stated that "[w]hen he has an exacerbation of exertional dyspnea he has gasping for his breath.

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[19] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…" In *Cornett v. Benham Coal, Inc.,* 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4).

[20] "The diagnosis of asthma should be considered in any individual who wheezes." THE MERCK MANUAL, p. 619 (14th Ed. 1982). Asthma is defined as "a condition marked by recurrent attacks of paroxysmal dyspnea, with wheezing due to spasmodic contraction of the bronchi." DOLAND'S POCKET MEDICAL DICTIONARY, p. 78 (23rd Ed. 1982).

He has not had wheezing." Dr. Renn merely listed asthma as his respiratory system diagnosis. He did not provide a rationale for his diagnosis of asthma. As Dr. Renn's opinion is less thorough and reasoned than the opinions of Drs. Crisalli and Zaldivar, I give his opinion less weight. Dr. Crisalli provided a detailed and thorough examination. Dr. Crisalli concluded that the Claimant's studies "give support" to an asthma diagnosis. This statement by Dr. Crisalli displays an effort by Dr. Crisalli to be all-inclusive in the pulmonary problems Claimant's evidence may demonstrate. Dr. Crisalli was clear in his determination that Mr. Taylor has pneumoconiosis. Dr. Crisalli provided a detailed and reasoned explanation for his diagnosis of coal workers' pneumoconiosis. He also provided a reasoned explanation of why Claimant's medical evidence may illustrate that Claimant has an asthma condition in addition to coal workers' pneumoconiosis. As such, I give more weight to Dr. Crisalli's opinion than Dr. Renn's opinion.

Dr. Zaldivar did not make a diagnosis of asthma. Dr. Zaldivar testified that the Department of Labor "questionnaire" does not explore wheezing and shortness of breath when exposed to chemicals or perfumes. Furthermore, Dr. Zaldivar testified that the Claimant said he didn't have any wheezing. (EX 8, p.11). When asked during a deposition if the Claimant had any history consistent with asthma, Dr. Zaldivar responded "[w]ell, not other than the hay fever that he told me about, which is not necessarily asthma. It's just an allergic problem." (EX 8, p.11). Dr. Zaldivar explained that cough and sputum production, which are symptoms complained of by Claimant, is a common cause of asthma. Dr. Zaldivar also stated that cough and sputum production are a common cause of gastric reflux and Claimant told Dr. Zaldivar he has heartburn. (EX 8, p.12). Dr. Zaldivar concluded that Claimant's obstructive impairment is due to coal dust exposure. When asked during his deposition if Claimant's mild obstruction could also be a result of asthma, he responded that it is possible. He clarified, however, that the diffusing capacity would not be reduced in asthma. Dr. Zaldivar concluded that Claimant has a reduced diffusion capacity. Thus, he stated "the mild diffusion impairment is more in keeping with some degree of lung destruction rather than an asthmatic problem." (EX 8, p.21). Furthermore, as noted above, Dr. Zaldivar described the necessary reversibility to find an asthmatic component. He did not find the necessary reversibility when he examined the Claimant. Based on his examination report and deposition testimony, I find Dr. Zaldivar diagnosis of coal workers' pneumoconiosis reasoned and comprehensive. Furthermore, Dr. Zaldivar's opinion is supported by the Claimant's medical evidence. The Claimant's testimony and statements to the examining doctors never discuss wheezing or a history of asthma. The only evidence from the Claimant's treating physician, Dr. Farooq, is that he referred the Claimant to a cardiologist to evaluate some chest pain complained of by Claimant. Based on Dr. Zaldivar's reasoned and detailed explanations, I give more weight to the opinion of Dr. Zaldivar than Dr. Renn.

Drs. Crisalli, Renn and Zaldivar provided complete pulmonary evaluations of the Claimant. Dr. Wiot testified regarding his interpretation of Claimant's X-ray evidence. Due to Drs. Crisalli, Renn and Zaldivar providing a complete analysis of claimant's medical history, I find the reports and testimony of Drs. Crisalli, Renn and Zaldivar more persuasive than the testimony of Dr. Wiot. In weighing the reports of Drs. Crisalli, Renn and Zaldivar, Drs. Crisalli and Zaldivar diagnosed pneumoconiosis and Dr. Renn concluded the claimant did not have pneumoconiosis. As such, a majority of the physician opinions concluded the Claimant has pneumoconiosis.

Dr. Crisalli determined that Mr. Taylor has a mild restrictive defect. Dr. Crisalli also found a mild obstructive defect in the post-bronchodilator pulmonary function study he performed. Dr. Crisalli determined that the pulmonary impairment may be related to coal dust exposure. Dr. Crisalli testified that coal workers' pneumoconiosis can cause a significant obstructive defect. Dr. Zaldivar concluded that Mr. Taylor has a mild airway obstruction. He attributed Mr. Taylor's obstructive defect to coal dust exposure. Dr. Renn also found a concomitant obstructive airway disease. Dr. Renn, however, stated that Mr. Taylor's pulmonary impairment is not related to coal dust exposure.

The legal definition of pneumoconiosis may consist of an obstructive defect. As such, in addition to the majority of the physician opinions finding clinical pneumoconiosis, I also find that a majority of the physician opinions establish legal pneumoconiosis.

On September 5, 1996, the West Virginia Occupational Pneumoconiosis Board concluded that the Claimant submitted sufficient evidence to justify a diagnosis of occupational pneumoconiosis with no more than 20% pulmonary functional impairment attributable to the disease. The Board credited Claimant with 37 years of coal dust exposure. (DX 9).

A general disability determination by a state or other agency is not binding on the Department of Labor with regard to a claim field under Part C, but the determination may be used as some evidence of disability or rejected as irrelevant at the discretion of the fact-finder.[21] *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984) (opinion by the West Virginia Occupational Pneumoconiosis Board of a "15% pulmonary functional impairment" is relevant to disability but not binding). *McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988). Thus, I give the state determination some weight as to the existence of pneumoconiosis.

After reviewing the X-ray evidence and physician reports together, I find the claimant has met his burden of proof in establishing the existence of pneumoconiosis. Although a majority of the X-ray evidence does not prove the existence of pneumoconiosis, a majority of physician opinions prove both clinical and legal pneumoconiosis. Additionally, the physician findings of pneumoconiosis are supported objectively by three positive X-ray readings. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the

[21] See § 718.206 "Effect of findings by persons or agencies." (65 Fed. Reg. 80050, Dec. 20, 2000) (Effective Jan. 19, 2001). If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Nor does the record contain contrary evidence that establishes the claimant's pneumoconiosis arose out of alternative causes.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[22] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718.

The record contains pulmonary function studies performed on September 26, 1995, September 23, 1999, March 14, 2001, November 14, 2001, and November 12, 2002. The only study with a qualifying result is the November 12, 2002 pre-bronchodilator study performed by Dr. Renn. In his medical report, Dr. Renn stated that the spirometry is consistent with a moderately severe restrictive ventilatory defect. Thus, the claimant did not prove total disability based on the results of the pulmonary function studies.

[22] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii).

Arterial blood gas studies were performed on March 14, 2001, November 14, 2001 and November 12, 2002. None of the studies produced a qualifying result. Thus, the claimant did not prove total disability based on the results of the arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

As noted above, Drs. Crisalli, Renn and Zaldivar examined the Claimant. Although each doctor found some form of pulmonary impairment, none of the doctor's concluded that Mr. Taylor is totally disabled. As such, the claimant did not prove total disability by a physician opinion.

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms do not render him unable to walk short distances or do some lifting, I find he is capable of performing his prior coal mine employment.

I find the claimant has not met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability[23]

Since I have found that the evidence of record fails to establish that Mr. Taylor suffers from a total respiratory disability, I accordingly find that Mr. Taylor failed to establish that he suffers from a total respiratory disability due to pneumoconiosis.

[23] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. __, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has not established that a material change in condition has taken place since the previous denial, because he has not proven total disability due to pneumoconiosis. The claimant has pneumoconiosis, as defined by the Act and Regulations. The pneumoconiosis did arise out of his coal mine employment. The claimant is not totally disabled. He is therefore not entitled to benefits.

ORDER[24]

It is ordered that the claim of JESSE D. TAYLOR for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of**

[24] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.
[25] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.